

<p align="center"><b>STATE OF VERMONT</b>  <b>AGENCY OF HUMAN SERVICES</b>  <b>DEPARTMENT OF CORRECTIONS</b></p>	<p><b>Title: Case Management</b></p>		<p align="center"><b>Page 1 of 5</b></p>
<p><b>Chapter:</b>  <b>Security and Supervision</b></p>	<p align="center"><b># 371.02</b></p>	<p><b>Supersedes</b> #371.02 (dated 06/01/2012); #371.05 (dated 06/01/2012); #371.07 (dated 12/30/2002); #373.01 (dated 06/01/1993); #430.10 (dated 06/01/2012); Interim Procedure on Response Supervision Contact Standards – Field (dated 06/01/2012); Deletion of #371.17 Offender Contact Standards for Field Services Programs and New Interim Procedure on Response Supervision Contact Standards – Field (dated 01/01/2012); Interim Revision Memo – Case Staffings (dated 01/17/2012)</p>	
<p><b>Attachments, Forms &amp; Companion Documents:</b>  All attachments, forms, and companion documents associated with this directive are available on the Department’s website.</p>			
<p><b>Local Procedure(s) Required:</b> Yes - for establishment of written facility protocols.  <b>Applicability:</b> All staff (including contractors and volunteers)  <b>Security Level:</b> “B” – Anyone may have access to this document.</p>			
<p align="center"><b><u>FOR STAFF COMMENT 4-28-16</u></b></p>			

- 1    **PURPOSE**
- 2    This administrative directive outlines the Vermont Department of Correction’s (DOC) general
- 3    approach, principles, and philosophy towards the case management of all offenders under DOC
- 4    supervision. This directive summarizes the holistic and collaborative approach of the DOC
- 5    concerning effective offender case management in order to promote positive changes in offender
- 6    behavior, successful reentry, and reduced recidivism.
- 7    Offenders in the custody of, and under supervision of, the DOC present with a variety of recidivism
- 8    risk factors. Vermont offenders are generally diverse and often present with complex behavioral,
- 9    mental health and substance abuse needs. The DOC’s holistic and collaborative approach to case
- 10   management includes the: (1) empirical assessment of risk and criminogenic needs; (2) identification
- 11   of appropriate risk reduction interventions that are evidence based (adhere to risk, need, and
- 12   responsivity principles); (3) development of collaborative case plans; and (4) utilization of core
- 13   correctional practices.
- 14   The purpose of this holistic and collaborative approach is to: (1) assess an offender’s overall risk to
- 15   recidivate; (2) address the criminogenic and responsivity needs of the offender as well as stability
- 16   factors (e.g., housing, medical care, transportation); (3) support the offender in taking responsibility

1 for their criminal behavior and to actively engage in his/her case plan development; (4) provide  
2 opportunities for community partnership and family involvement in the case planning process; (5)  
3 identify and connect offenders to DOC risk reduction interventions, community programs, and  
4 community supports as appropriate; (6) continually engage offenders in the change process by  
5 employing core correctional practices; and (7) enhance community safety.

## 6 7 **POLICY**

8 It is the DOC's philosophy that case management and case planning is a collaborative approach and  
9 the core process by which services are organized to promote, support, and guide offender change and  
10 to enhance community safety. The DOC's case management directive is grounded in the key Agency  
11 of Human Services (AHS) practices; it is client-centered, results-oriented, strengths-based, and  
12 holistic.

13 The DOC defines successful reintegration as offenders becoming prosocial citizens of society. The  
14 DOC believes that the best means of ensuring an offender's successful reintegration into their  
15 community, as well as enhancing community safety, is through effective case management.  
16 Although control and surveillance are legitimate strategies, community safety is better achieved  
17 through a strategy that encourages behavior change. The ultimate goal of effective case management  
18 is behavior change, risk reduction, and the reduction of recidivism.

19 Case management and case planning begins with, and is based on, empirical assessment of risk and  
20 criminogenic needs. Research demonstrates that matching the intensity of the interventions to the  
21 assessed level of risk (i.e., more intensive strategies for higher risk offenders) results in better  
22 offender outcomes.<sup>1</sup> Research also demonstrates that offender outcomes are improved when  
23 intervention strategies address criminogenic needs. The risk assessment will form the basis of the  
24 offender's case plan. Case plans will target the offenders' top four to six criminogenic needs over the  
25 course of DOC supervision. In addition to addressing the offender's responsivity needs (e.g.,  
26 intelligence level and functional abilities, gender, cultural background, developmental age, mental  
27 health condition, housing, medication, transportation, I.D., financial support) that interfere with the  
28 offender's ability to address his/her criminogenic need(s).

29 The DOC believes that case management is ongoing and dynamic. Case management is a process  
30 that begins as early as sentencing and continues seamlessly until the offender is discharged from  
31 supervision. As offenders' circumstances change significantly either positively or negatively (e.g.,  
32 completion of a program or compliance violations) and as reassessments reflect changes in risk levels  
33 or risk factors, case management and case plans are reshaped, reflecting updated goals and strategies.

34 Case management is a collaborative process that includes classification, and assessment of risk,  
35 needs, and responsivity issues, as well as input from the offender and his/her support system. This  
36 information informs the development of an individualized case plan which effectively uses  
37 correctional and community resources. This then provides for effective supervision and support of  
38 the offender throughout his/her sentence. The offender's support system includes, but is not limited

---

<sup>1</sup> Bonta, James, and D. A. Andrews. *Risk-need-responsivity Model for Offender Assessment and Rehabilitation*. Ottawa: Public Safety Canada, 2007. Public Safety Canada, 2007. Web.  
<<http://www.pbpp.pa.gov/Information/Documents/Research/EBP7.pdf>>.

to, DOC Correctional Services Specialist (CSS) staff, DOC education and workforce development staff, DOC victim services staff, DOC medical staff, DOC reentry coordinators, DOC contract staff, the offender, familial relationships, friends, pro-social supports, and community partners.

In addition to the individualized aspects of case management, the DOC aims to incorporate core correctional practices into its overall case management philosophy. Core correctional practices are evidence-based practices that have been proven effective in changing offender behavior and reducing recidivism. These practices include relationship building, anti-criminal modeling, structural learning, cognitive restructuring, problem solving, effective reinforcement, effective disapproval, and effective use of authority.

The primary goal of the DOC case management process is to engage the offender in behavior change, risk reduction, reduction of recidivism, and to enhance community safety. The means to this end is outlined in the offender case plan.

The offender case plan outlines goals for addressing risk, need, and responsivity areas that will lead the offender toward successful reentry and stability within the community. The case plan is a written document that describes the offenders' goals over their time in DOC supervision; it includes specific steps to reach those goals, and realistic timelines. The case planning process involves the offender in constructing the plan; aligns case plan activities and strategies with interventions that address offender specific criminogenic needs; and is specific, concrete and easy to follow.

## **AUTHORITY**

28 V.S.A. § 2a; 28 V.S.A § 101(1)-(2); 28 V.S.A. § 102(c)(1),(2),(3),(8) and (9); 28 V.S.A § 254; 28 V.S.A § 352; 28 V.S.A § 706; 28 V.S.A § 721; 28 V.S.A. § 723; 28 V.S.A. § 724; 28 V.S.A § 808.

## **REFERENCE**

Agency of Human Services Four Key Practices. *APA Rule #00-10/Policy #256 Community Notification*; Department of Corrections Administrative Directives #76.05 *Positive Reinforcement*, #254.04 *Case Documentation – Electronic*, #323.01 *Inmate Release Money*, #344.01 *Collaborative Community Supervision*, #371.11 *Level C Performance Expectations*, #371.15 *Conditional Re-entry*, #371.17 *Offender Contact Standards for Field Services Programs*, #501.01 *Restorative Justice Programs*, and #502.01 *Victim Notification – Automated (VANS) & Non-automated*. American Correctional Association, Standards for Adult Correctional Facilities, 4<sup>th</sup> Edition, 2003, Standard 4-4442. American Correctional Association, Standards for Adult Probation and Parole Field Services, 3<sup>rd</sup> Edition, August, 1998, Standards 3-3125, 3-3131, 3- 3132, and 3-313

## **PROCEDURAL GUIDELINES**

### Risk, Need and Responsivity

The DOC adheres to the risk, needs, and responsivity model in the DOC's programs and services. The risk principle states that offender recidivism can be reduced if the level of intervention services provided to the offender is proportional to the offender's risk to re-offend. The principle has two parts to it: 1) level of intervention and, 2) offender's risk to re-offend. This is effectively the

1 identification of who will most benefit from risk reduction services. DOC identifies these individuals  
2 by conducting risk assessments on individual offenders. The risk assessments identify a reliable way  
3 of differentiating low risk offenders from high risk offenders. Once this identification is completed,  
4 appropriate intervention can be pursued.

5 The second portion of the model, need, identifies the criminogenic need areas which an individual  
6 shall address through intervention. The DOC identifies these criminogenic need areas and then an  
7 offender's top four-six criminogenic needs are identified in the offender's case plan and intervention  
8 methods are utilized. The DOC primarily targets interventions at eight identified need areas (1)  
9 criminal history; (2) antisocial personality pattern; (3) pro-criminal attitudes; (4) social supports for  
10 crime; (5) substance abuse; (6) family/marital relationships; (7) school/work; and (8) prosocial  
11 recreation activities. In addition to the above-identified criminogenic needs, the DOC also targets  
12 interventions tailored to offenders who have committed violent crimes and/or crimes of a sexual  
13 nature.

14 The final component of the model is the responsivity principle. The responsivity principle is the  
15 section of the model which is tailored to the individual needs of the offender. It encompasses the  
16 individual components necessary to ensure interventions in the identified criminogenic need areas are  
17 most effective at teaching offenders new behaviors. The responsivity principle allows the DOC to  
18 also utilize other services, such as transitional housing and community-based resources (also referred  
19 to as stability factors) to ensure that an offender's individual circumstances are accounted for in  
20 ensuring that s/he is able to focus on social change.

### 21 Risk Reduction Interventions

22 The DOC administers correctional interventions in its effort to reduce the risk to persons and property  
23 from criminal behavior.<sup>2</sup> These interventions with offenders enhance successful reentry into the  
24 community, as well as to promote positive citizenship within the state and community. DOC  
25 employs-evidence based practices which have demonstrated positive effects in reducing the risk of  
26 recidivism and public harm and that promote offender success. Risk reduction interventions are  
27 offered to offenders who qualify based on risk assessment and/or the egregiousness of their crimes.  
28 The DOC recognizes that life skills, education, and workforce development reduces risk and can  
29 increase the capability of offenders to grow and develop by providing them with the knowledge and  
30 skills necessary to be responsible and productive members of society. DOC uses multiple venues to  
31 support the attainment of workforce readiness skills, including correctional industries, work camp,  
32 and facility employment.

33 The DOC provides interventions which target evidenced based criminogenic needs, specifically those  
34 identified as anti-social cognitions, anti-social peers, anti-social personality traits, education,  
35 employment, substance abuse, family and social supports, leisure and violence. The DOC employs  
36 evidenced based interventions in a holistic model.

### 37 38 Core Correctional Practices

39 The DOC case management process embraces the use of eight core correctional practices. They are:  
40 (1) relationship skills; (2) anti-criminal modeling; (3) structured learning; (4) cognitive restructuring;  
41 (5) problem solving; (6) effective reinforcement; (7) effective disapproval; and (8) effective use of

---

<sup>2</sup> These programs are administered pursuant to [28 V.S.A. § 1\(a\)](#)

1 authority. These are concrete practices that correctional staff can use with offenders to be more  
2 effective at changing behavior and reducing recidivism.<sup>3</sup>

### 3 Victim Involvement

4 It is the mission of the DOC to support community safety by ensuring offenders serve their sentences,  
5 take responsibility for their crimes, and have opportunities to make amends to their victims. The  
6 DOC believes that victims of crime can have an important role in both the supervision and treatment  
7 of criminal offenders. The DOC seeks to integrate victims' perspectives throughout the supervision  
8 process through collaboration, primarily with direct communication with field and facility casework  
9 staff. In addition, the DOC's Victim's Services Unit serves a consultative and expert role providing  
10 support to both DOC staff and victims when needed.

11 The integration of a victim voice, when voluntary, into the case management process provides an  
12 important resource for DOC staff in its efforts to keep the victim informed, encourages offender  
13 accountability, and working with offenders to address the harm their behavior has caused to the  
14 victim and community.

### 15 Gender Responsivity

16 The DOC recognizes that there are important differences between offenders in terms of offending  
17 histories, risk factors, and life circumstances, and that gender makes a difference when implementing  
18 case management strategies.

19 Within the robust body of research relating to risk, need, and responsivity, the DOC acknowledges  
20 the growing evidence regarding the role of gender in the criminal justice system. This evidence  
21 demonstrates that women's profiles and pathways to crime are different than men's, and that women  
22 respond differently to correctional interventions than men. As such, the case management process in  
23 working with the male and female populations shall be informed by this research. While a common  
24 framework of case management will be used for both men and women, the individual characteristics  
25 of the genders must be taken into consideration when performing case management and case  
26 planning responsibilities.

27 A growing body of research and evidence asserts that while gender neutral criminogenic risk  
28 assessments are predictive of risk for women, women have unique needs that are not captured in  
29 current gender specific risk/needs assessments. Therefore, the case management process with women  
30 should also consider these unique needs. Case plans should be informed by criminogenic risk factors  
31 in addition to gender responsive unique needs. Case planning should also incorporate gender  
32 responsive strengths and protective factors to build upon.

## 34 **IMPLEMENTATION**

35  
36 This directive will be implemented with formalized training for all current staff.  
37

---

<sup>3</sup> Core Correctional practices were first introduced in the 1980s as a way to increase the therapeutic potential of rehabilitative programs. Over 700 evaluations show that the programs that incorporate these practices with the risk, need, responsivity model have been associated with intervention effects compared to those that do not.